Community Health Centers:
A Vital Strategy for Community Development

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NCB Capital Impact

Community health centers contribute in significant ways to the growth and stability of low-income neighborhoods. Their impact has been long-standing, yet not widely known in the community development field. With the nation's health-care system poised for significant change, it is an appropriate time to shed light on the link between health centers and community development.

The benefits that health centers deliver to communities reach well beyond their core purpose of improving access to essential health services for low-income people. The health outcomes they achieve increase worker productivity, which can lead to poverty reduction. Further, health centers provide direct employment to local residents, including entry-level jobs with career ladders. Health centers purchase goods and services from local businesses, thus spreading indirect benefits more broadly through the multiplier effect. The facilities constructed by health centers bring capital investment to underserved communities and anchor commercial revitalization.

As community development investments, health centers have an excellent track record of responsibly using debt to finance their growth. With appropriately structured financing, health centers have been able to develop modern, efficient facilities that enhance the quality of care provided while stimulating economic development, assuring their continued role as important economic engines, as well as essential components of the nation's health care system.

What Are Community Health Centers?

Community health centers (CHCs) are nonprofit organizations that meet the primary-care needs of individuals and families living in low-income communities, including many of the nation's Medicaid recipients and uninsured, in areas traditionally underserved by physicians. Health center services are provided to all, regardless of the patients' ability to pay, and services are tailored to the cultural and linguistic needs of individual constituencies. Health-care practices have evolved, as have community health centers, growing from small storefront clinics in the late 1960s to large comprehensive health-care facilities today. As health centers have evolved into organizations of greater sophistication and complexity, their impact on the surrounding communities has grown as well.

Community health centers were originally created as part of the Office of Economic Opportunity in the 1960s War on Poverty, at the same time that community development corporations (CDCs) were formed. Both CHCs and CDCs share a common focus on local empowerment and development through the concept of maximum feasible local participation. Health centers were conceived from a grassroots movement and remain deeply

embedded in their local communities. To this day, CHCs require that 51 percent of the governing board be composed of consumer users of the health center's services.

Community health centers act as the nation's health-care safety net, offering a full spectrum of care that is sensitive to each community's unique needs from more than 7,000 delivery sites in underserved urban and rural areas nationwide.[1] Most health center patients live at or below the federal poverty level, which is less than $11,000 in annual income for a single person or about $22,000 for a family of four.[2] To help provide services to such a low-income client base, community health centers rely on a combination of federal and state grants, Medicaid and Medicare reimbursement, patient fees, private insurance payments, and donations, underscoring the need for cost-effective delivery.

So important is the need for community health facilities that the Bush administration increased federal operating support to enable community health centers to double their capacity by opening 1,200 new or expanded service sites between 2002 and 2006, and in 2009 the Obama administration has provided more than $1 billion in grants for facilities and technology through the American Recovery and Reinvestment Act of 2009.

Most health centers are not just small organizations working to meet the needs of low-income people. Many operate from multiple sites around the community, from small school-based clinics to large comprehensive-care facilities that provide a combination of primary care, dental care, and behavioral health services. A typical health center sees approximately 50,000 patient visits annually, has an annual operating budget of $10 million or more, three to five clinic sites, and 60 to 80 employees, including physicians, nurses, and other health practitioners, as well as accounting staff and other administrative positions. Some of the larger organizations have budgets approaching $100 million, twenty or more sites, and 200 or more employees.

To help improve health outcomes for their patients and strengthen operating efficiency, community health centers also make a significant investment in equipment and technology. Federal stimulus dollars are targeted toward the purchase of electronic medical records systems that allow health centers to interface across sites, with hospitals and specialty providers, and with other health-care organizations. This investment will place community health centers near the forefront of the latest improvements in managing patient care.

Impact

As of 2007, 1,100 federally funded CHCs operating from 7,000 sites served more than 16 million patients. Nearly 40 percent of those patients were uninsured and 35 percent were enrolled in the Medicaid program.[3] These health centers are improving health outcomes for medically underserved populations, creating employment and other economic opportunities and stimulating investment in low-income areas.

1 National Association of Community Health Centers, US Health Center Fact Sheet, 2008.

2 US Department of Health and Human Services, http://aspe.hhs.gov/poverty/09poverty.shtml.

3 National Association of Community Health Centers, *US Health Center Fact Sheet*, 2008.

Better Care, Lower Cost

People who lack primary health-care services are at greater risk for poor health outcomes and are more likely to use more expensive emergency room care. Low-income people and communities are among the most vulnerable. Access to primary health care can reduce avoidable hospitalizations, help to manage chronic conditions, and lead to less serious episodes of illness. As medical "homes" for low-income individuals, CHCs are the first line of defense. Studies show that both uninsured and insured patients without access to CHCs were twice as likely to go without the care they need, even those who were privately insured.[4]

Compared to Medicaid patients treated elsewhere, health center Medicaid patients are between 11 percent and 22 percent less likely to be hospitalized for avoidable conditions and are 19 percent less likely to use the emergency room for avoidable conditions. They also have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient and other care costs.[5]

With a heavy emphasis on prevention, health centers help patients manage the most prevalent diseases or disease factors facing low-income communities, such as diabetes, hypertension, substance abuse, and HIV/AIDS. For example, diabetes patients at health centers receive more care than other low-income diabetics,[6] and have lower rates of low-birth-weight babies when compared to both other low-income patients and all U.S. patients.[7] Of critical importance, CHCs have reduced health-care disparities based on race and income.[8]

A study released in August 2007 by the National Association of Community Health Centers (NACHC), in collaboration with the Robert Graham Center and Capital Link, found that medical expenses for health center patients are 41 percent lower ($1,810 per person annually) compared to patients seen elsewhere. As a result, they save the health-care system between $9.9 and $17.6 billion a year.[9]

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4 R. Politzer et al., "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care," Medical Care Research and Review 58 (2) (2001): 234–48.

5 Falik et al., "Comparative Effectiveness of Health Centers as Regular Source of Care," JACM 29 (1) (2006): 24–35. Falik et al., "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers," Medical Care 39 (6) (2001): 551–56. B. C. Duggar et al., "Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers," Center for Health Policy Studies, 1994.

6 L. Shi, "A Review of Community Health Centers: Issues and Opportunities," Washington, D.C., May 25, 2005. Based on Community Health Center User Survey, 2002, and National Health Interview Survey, 2002.

7 L. Shi et al., "America's Health Centers: Reducing Racial and Ethnic Disparities in Prenatal Care and Birth Outcomes," Health Services Research 39 (6) (2004): pt. 1, 1881–1901.

8 P. Shin, K. Jones, and S. Rosenbaum, "Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low Income Communities," September 2003. Prepared for NACHC, http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/GWU_Disparities_Report.pdf.

9 NACHC, Robert Graham Center, and Capital Link, Access Granted: The Primary Care Payoff, August 2007.

Economic Impact

Health centers are more than service providers. They are employers and local businesses that have a significant impact on the surrounding community. Using available economic modeling tools, community health centers are able to quantify the direct and indirect effect of providing jobs and income to employees and other businesses, which then ripples through the local economy.

The NACHC study found that in 2005, CHCs directly generated over $7 billion of revenue and employed 90,000 people nationally. Using the IMPLAN model for estimating multiplier effects, the study shows total economic impact of $12.5 billion and the creation of 143,000 jobs in some of the country's most economically deprived neighborhoods.[10]

Table 1. Total Economic Activity Stimulated by CHCs, 2005[11]

	Total Economic Impact	Employment (Total FTEs)
Direct	$7,261,975,096	89,922
Indirect	$1,124,387,922	10,233
Induced	$4,172,328,893	42,918
Total	$12,558,691,911	143,073

Anchoring Revitalization

In many cases, when health centers improve their facilities, they spark community revitalization. Examples of the impact of health centers on local revitalization abound. In Brockton, Massachusetts, a New England town that has been struggling with the effects of the loss of a manufacturing and industrial base, the Brockton Neighborhood Health Center (BNHC) is an example of a facility that has grown from humble beginnings to being a large and visible economic engine in the city's downtown. BNHC is the only community health center in this city of 94,000, which is economically distressed with poverty levels significantly exceeding statewide averages. Brockton's higher level of poverty is the result of the loss of a manufacturing base in recent years since its core shoe- and boot-making industry moved out

10 IMPLAN's output, earnings, and employment figures are aggregated based on direct, indirect, and induced economic effects defined as:
Direct effects: represents the response for a given industry (in this case Total Operating Expenditures of health centers).
Indirect effects: represents the response by all local industries caused by "the iteration of industries purchasing."
Induced effects: represents the response by all local industries to the expenditures of new household income generated by the direct and indirect effects.

11 NACHC, Robert Graham Center, and Capital Link, Access Granted: The Primary Care Payoff, August 2007, www.nachc.com/research.

of the country. An estimated 4,200 jobs have left the city during the last ten years.

Because this area faces high rates of disease, illness, and teen pregnancy in addition to low rates of prenatal care, BNHC's services are critical for Brockton's population. Despite the fact that more than half of Brockton's mothers receive publicly funded prenatal care, more than a third do not receive prenatal care in their first trimester. Most of Brockton's disease rates, especially HIV/AIDS and other STDs, particularly among adolescents, far exceed state rates. In addition, most of Brockton's residents may not have access to primary care, leaving many residents to suffer from manageable conditions such as asthma and pneumonia.

As the demographic profile of Brockton has changed, the health center has worked to focus on providing culturally competent care. Almost 40 percent of the health center's 12,000 patients require translation assistance. In response to this need, the center employs staff members fluent in Cape Verdean Creole, Portuguese, Spanish, French, and Haitian Creole. Approximately 70 percent of patients live at or below the federal poverty level. Most of the center's active patients live in Brockton, with others residing in the neighboring communities of Stoughton, about three miles northwest of Brockton, and Taunton, about ten miles south. A smaller segment lives in the smaller towns situated east of Brockton toward the coast. No other health centers are available to people living in these small towns.

The need for health care in greater Brockton is acute. BNHC began operating from a mobile van in a church parking lot in 1994, and over the years it has grown by adding leased sites throughout the city. In 2007, the center moved into a new 57,000-square-foot, five-story facility on a vacant lot in downtown Brockton, which has allowed them to consolidate leased sites and more than double patient capacity.

The health center's board and management chose to develop its new facility in the heart of downtown. This site anchors one end of the city's main street, combining the entire health center's scattered sites into one facility and generating significant additional traffic to Brockton's downtown. The center also partnered with a small local pharmacy, which moved from its location down the street to a space in the new center, thus supporting a locally owned business while also providing needed access to pharmaceuticals under the health center's roof. As evidence of the project's positive impact on Brockton's downtown, part of the funding for the health center came from the Economic Development Administration of the U.S. Department of Commerce. Additional financing came through New Markets Tax Credits, using the subsidy to reduce the health center's annual debt service expense and allocate more of its cash flow to providing services to low-income patients.

This project is expected to create more than 92 new jobs at the health center. Using the multiplier effect, the project can be expected to create more than 276 indirect jobs and bring millions of dollars of additional revenue into the Brockton area.

Financial Strength and Facility Needs

In this time of economic uncertainty, community health centers face many challenges in providing high-quality primary care to low-income patients. Uninsured populations increase

with growth in unemployment, placing pressure on providers and facilities. State budget deficits force reductions in entitlement programs. Health centers find it difficult to recruit and retain staff willing to work for lower wages in what are often older facilities than their private-practice equivalents. In addition to rising costs, shifting reimbursement streams, and the strain of a constantly growing demand for their services, health centers have traditionally encountered difficulty in obtaining appropriately structured financing for working capital, building projects, and equipment needs, often due to a perception that their clientele, their funding, and their location make them a higher-than-average risk.

Fortunately, experience has shown that community health centers and other community-based health-care providers are remarkably resilient and resourceful. Even as there have been times of tight state budgets and reductions in reimbursement, community health centers have been and continue to be financially stable with diverse revenue sources. Maintaining stability requires creativity, dedication to managing costs, and improving efficiency in the face of a challenging economic environment.

Another example of a resilient, innovative CHC is Community Health Center, Inc., based in Middletown, Connecticut, serving the entire state from multiple sites. This health center took advantage of its eligibility to participate in a federal pharmaceutical purchasing program by partnering with a for-profit pharmacy that co-locates in a number of the health center's clinical sites. This partnership allows the health center to connect its patients with low-cost pharmaceuticals through the federal pricing program without having the logistical and investment burden of operating a pharmacy of its own. It also makes use of the buying power of a large pharmacy chain to provide patients with access to other medical supplies not covered by the federal pricing program–and patients don't even have to leave the health center property. This allows the health center to meet patient needs and improve health outcomes because patients don't have to make a second trip to a pharmacy in another location that might be difficult to reach.

Although they serve a predominantly low-income population, a community health center's facilities do not have to be in poor repair. Health centers suffer from the perception that they are a health-care provider of last resort, with outdated facilities to match. But with appropriately structured financing, health centers in many parts of the country have been able to improve the efficiency and capacity of their facilities while maintaining high-quality care for their patients. One health center's board and management recently undertook the construction of a new facility to be a focal point for their community that would not, in their own words, "look like a clinic for poor people."

South of Market Health Center (SMHC) in San Francisco is an excellent example of a project that was developed to act as a community focal point. For more than 30 years, SMHC has been the primary source of medical and dental care for the low-income, uninsured, homeless, and medically-needy residents of the city's South of Market (SOMA) neighborhood as well as parts of the adjacent Tenderloin district.

SOMA has always been among the more affordable neighborhoods in San Francisco and

is home to a large number of lower-income and immigrant populations. The health center's service area is represented by seven contiguous census tracts that consist of a densely populated urban area with a diverse mix of residents. Many seniors and extremely low-income families live in the center's service area. Additionally, the infamous Sixth Street Corridor, the well-known homeless/near-homeless, transient, and substance-abusing area of San Francisco, is located one block north of the current clinic site. Many single-room-occupancy hotels housing single adults are located along the Sixth Street Corridor.

A study conducted by the health center concluded that a greater proportion of SOMA residents live in poverty as compared to the city's residents as a whole. For example, the median household income of SOMA was half of that for the entire city, and the unemployment rate among SOMA residents was more than double that of citywide residents. The study also reported that the population in SMHC's service area had grown nearly 50 percent during the previous decade.

Although the dot-com boom of the 1990s was largely centered in the SOMA district, displacing many of its residents, new low-income housing supported by the city has since restored affordability to the area and drawn this population back.

To support the neighborhood's health-care needs, SMHC employs more than 40 full-time staff and offers an extensive array of family-oriented health services, including primary medical care, disease prevention, urgent care, dentistry, and podiatry. The health center also offers specialty programs such as women's health care (including family planning and prenatal and postpartum care) and management of high-risk diseases (such as HIV/AIDS services). Approximately two-thirds of the health center's patients are uninsured and one-third are homeless.

In 2007, the health center served 4,700 patients, generating more than 17,000 patient encounters, representing the maximum the current facility can accommodate. The health center has functioned at this capacity for more than ten years.

SOMA is in the midst of a project to construct a new site that allows the center to double its capacity as they move from a cramped and aged facility to a modern, more efficient one. The new health center is part of a campus that includes nearly 50 units of affordable housing (developed and financed by another organization). The new development will consist of two main buildings. The first building will be a five-story structure with three levels of housing over a two-level community health center. The second structure will be a four-story residential building situated along the rear boundary of the lot. The two structures will be separated by a courtyard. In total, the development project will offer 20,000 square feet for the community health center and 48 units of rental housing for low-income families. The new medical facility will have enough space to house the clinic administration as well as medical, dental, pharmacy, lab work, and x-ray services. Housing units will consist of one- to three-bedroom units, community rooms, and an outdoor playground.

The campus is located in a predominantly residential neighborhood with a handful of small service businesses in the immediate area. It replaces a former parking lot and is a notable improvement to the neighborhood. For every job the health center creates, it is esti-

mated that another 1.5 jobs will be created in the community to provide support services to the facility and its users.

Like many health centers, this facility was constructed with a combination of fundraising and debt. For this project, a strong capital campaign allowed the health center to raise a significant portion of the $15 million budget, which combined with support from the City of San Francisco Redevelopment Agency allowed the health center to cover approximately half of the project costs. The balance was financed with debt from NCB Capital Impact, a nonprofit lender, and New Markets Tax Credit equity, making this large project very affordable for a medium-sized health center. The table below shows how the financing was assembled.

Table 2. Sources and Uses of Funds

Sources		Uses	
NMTC Debt	$2,446,080	Land & Predevelopment	$2,241,567
Soft Debt	$6,903,701	Construction	$10,163,137
NMTC Equity	$3,184,564	FF&E	$1,000,000
SFRA Land Grant	$1,093,612	Soft Costs	$625,773
Fundraising	$1,513,203	Contingencies	$1,110,713
Total Sources	**$15,141,190**		**$15,141,190**

Although community health centers face many challenges in providing care to low-income individuals, the challenge of facilities development is not insurmountable. Using a variety of funding sources, health centers have been able to construct modern, efficient facilities that enhance the quality of care provided while improving and empowering their communities, assuring their continued role as important components of the nation's health-care safety net. Beyond their role as health-care providers, health centers are also economic engines that create jobs, improve their neighborhoods, and have a positive impact on their surrounding communities.

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Annie Donovan is chief operating officer of NCB Capital Impact. She is responsible for leading the company's efforts in innovative community lending, expert technical assistance, strategy formation, product innovation, and policy development. NCB Capital Impact supports people and communities to reach their highest potential at every stage of life.

References and Resources

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